Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare North Dallas

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-14-3279-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 30, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We used the correct modifiers."

Amount in Dispute: $621.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Coventry stands by the pricing."

Response Submitted by: Gallagher Basset Services, Inc 11940 Jollyville Road Suite 210-N, Austin, TX 78759

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 4, 2013	99213, 99080, 97140, 97112, 97110	$621.66	$119.22

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.

Issues

1. Did the requestor support claim was submitted within Division guidelines?
2. What is the rule that determines fee guideline?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as 4 – "The procedure code is inconsistent with modifier used or a required modifier is missing." Per 28 Texas Administrative Code §134.203(b) For coding, billing, reporting, and

reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. Review of the submitted documentation finds;

- Claim marked as reconsideration dated 06/25/2014 shows required modifiers for applicable codes
- Explanation of benefits dated January 9, 2014 and June 11, 2014 show codes in dispute with no modifier listed.

The requestor stated on documents included in medical fee dispute resolution request, "we used the correct modifiers." No documentation could be found to support this statement. The carrier's denial for codes 99080, 97140, 97112, 97110 is supported and will stand. However, CPT code 99213 does not require a modifier and will be reviewed per applicable rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.203(c) "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service annual conversion factor)."
    - Procedure code 99213, service date December 4, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.97873. The practice expense (PE) RVU of 1.1 multiplied by the PE GPCI of 1.017 is 1.1187. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.834 is 0.05838. The sum of 2.15581 is multiplied by the Division conversion factor of $55.30 for a MAR of $119.22.
3. The total allowable reimbursement for the services in dispute is $119.22. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $119.22. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $119.22.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $119.22 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January , 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.